YEAR 2000 SYMPOSIUM
INJURY CONTROL OBJECTIVES FOR CANADA
MAY 21-22, 1991, EDMONTON
INTERIM REPORT, JUNE 1991

A PROJECT FUNDED BY THE
OCCUPATIONAL HEALTH AND SAFETY
HERITAGE GRANT PROGRAM

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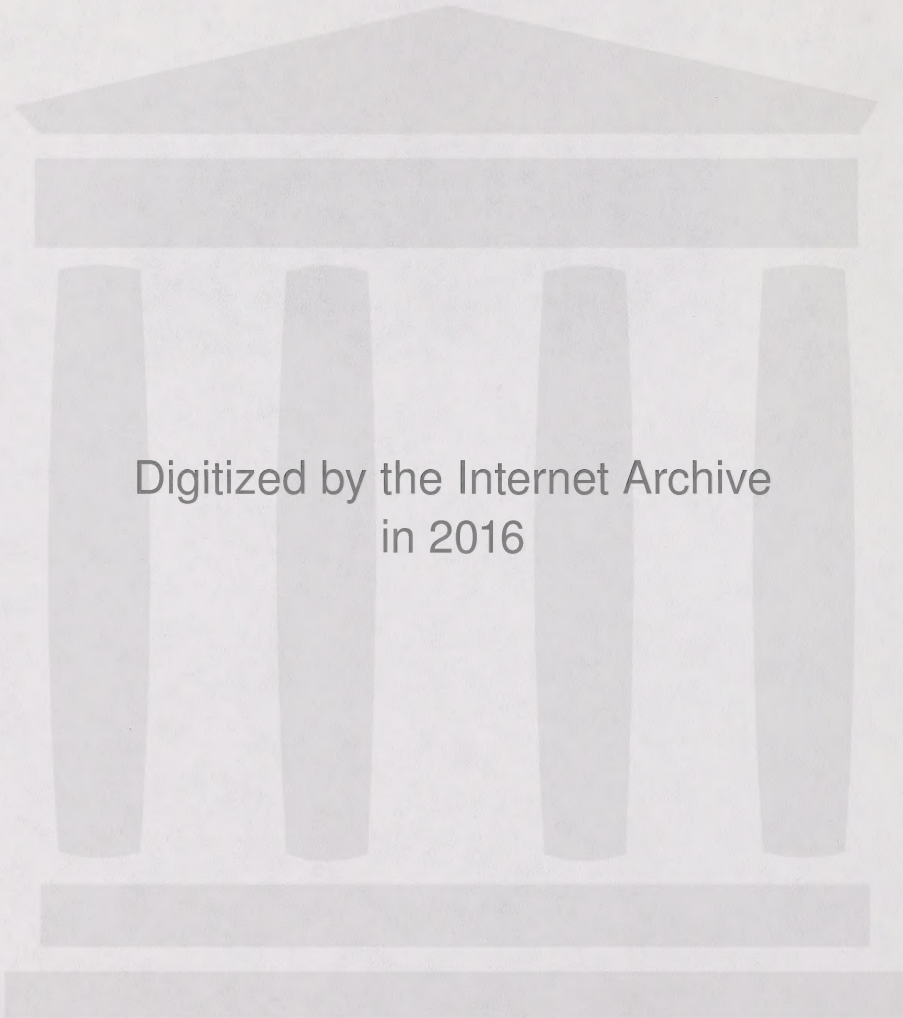

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I FOREWORD

For decades infectious diseases were the major causes of death and disability among Canadians. These diseases have been reduced or eliminated through prevention and health promotion, including immunization programs, sanitary engineering and improved nutrition.

Now preventable injury is the leading cause of mortality and morbidity among Canadians between the ages of one and 44. Chronic diseases and traumatic incidents leading to injury are among the major causes of ill-health in Canada, and it has long been recognized that the challenges posed by such modern causes of ill-health require preventive and promotional approaches. This view has been endorsed by the Lalonde Report "A New Perspective on the Health of Canadians" and the Epp Report "Health For All", both issued by the federal government. However, there has never been a coordinated, multi-sectoral approach to meet these challenges in the area of injury prevention.

On May 21-22, 1991, over 100 delegates gathered in Edmonton to participate in the first National Symposium to Establish Injury Control Objectives for Canada for the Year 2000. The ultimate challenge facing the participants was to formulate measurable, long term national injury control objectives. At the end of the Symposium it was agreed that this challenge could be successfully met, but that the setting of objectives is useful only if there is a broad consensus and the participation of health care professionals, governments, community associations and many other stakeholders across Canada.

The idea for the Year 2000 Symposium was born in 1990 after the Second Annual Injury in Alberta Conference. It was realized that while there was a great deal of activity in the injury prevention and control area in Canada, there seemed to be little coordination between different regions or different sectors.

The decision to hold the Symposium was prompted by three considerations:

* Injury is the leading cause of mortality and morbidity among Canadians between the ages of one and 44;
* There is little coordinating of injury control initiatives at the national level; and
* Many provinces are setting health goals including injury control.

These three considerations made it obvious that the time was ripe for a multi-sectoral consensus on establishing priority injury control objectives for Canada.

Preparation for the Year 2000 Symposium involved consultation with representatives of federal, provincial and territorial agencies, nonprofit organizations and academic institutions across Canada. Questionnaires were sent to potential participants to determine the issues that needed to be addressed in the course of the Symposium and a framework suitable for achieving maximum results in a short period of time. This consultation process indicated strong support for setting national objectives for injury control, as well as using the US document "Healthy People: Health Objectives for the Nation" as a starting point for developing those objectives.

The Year 2000 Symposium had immediate and long term goals.

The immediate goal was to formulate objectives for particular types of injuries. Five groups of delegates addressed:

* Transportation Injuries
* Sport and Recreation Injuries
* Home and Community Injuries
* Occupational Injuries
* Violent and Abusive Behaviour Injuries

The long term goal was to ensure that the objectives formulated by the five working groups are widely disseminated, and used in planning and evaluating injury control activities across Canada. It is only through the implementation of these objectives that achievable national injury control can become a reality.

This document provides a brief synopsis of the activities that took place at the Year 2000 Symposium, including the process that was followed, the conclusions that were reached and the recommendations that were made.

The comprehensive Final Report, to be produced with input from all Year 2000 Symposium participants and stakeholder groups, will be submitted in the Fall of 1991. The level of detail that will be contained in the Fall 1991 Final Report will show that, as a result of the Symposium, a national agenda can for the first time be prepared to control injury in Canada.

II YEAR 2000 SYMPOSIUM PROGRAM

	ACTIVITY
MONDAY, MAY 20	Registration & Group Chairpersons Meeting
TUESDAY, MAY 21	Welcome and Introduction of Speakers
	Opening Address: Mr. Hugh Walker, Manager and Director, Alberta Occupational Health & Safety
	Mr. James Harrell Deputy Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services: "How the USA developed health promotion and disease prevention objectives."
	Dr. Duncan Saunders: Tasks & Logistics
	Work Groups Session I
	Work Groups Session II
	Plenary Session - Reports from Sessions I & II
WEDNESDAY, MAY 22	Plenary Session: Mr. James Harrell: "How the USA plans to achieve their health promotion and disease prevention objectives."
	Work Groups Session III
	Plenary Session - Data Needs
	Work Groups Session IV
	Plenary Session - Reports from Sessions III & IV
	Plenary Session - Implementation of Objectives

III HOW WERE THE OBJECTIVES PRODUCED?

An excerpt from the US document "Year 2000 Injury Control Objectives for the Nation" was used as a starting point for formulating objectives relevant to Canada and its provinces. These objectives were circulated to leading individuals and agencies in the area of injury prevention and control to solicit comments and suggestions for the development of Canadian objectives in months preceding the Year 2000 Symposium.

The process that was used is as follows:

* In September 1990 a package was mailed to all who expressed interest in the Year 2000 Symposium. The package included:
    1) Details of the proposed US "Year 2000 Injury Control Objectives for the Nation".
    2) A structured response and comment form to be completed and returned by October 31, 1990 for collation.

  The purpose of this first response form was to get feedback on the criteria for selecting objectives, the range of injuries to be covered by these objectives and the specific objectives to include within different categories.

* In December 1990 a second package was mailed. This contained:
    1) A report on suggested additions, deletions, and changes to the original objectives.
    2) Proposed revised Injury Control Objectives for Canada.
    3) A structured response and comment form to be completed and returned by January 31, 1991.

  The purpose of this second response form was to get feedback on the responses to the first package and to get suggestions on the targets for the proposed specific objectives.

* In April 1991 a third package was mailed. This contained:
    1) A report on suggested additions, deletions, and changes to the original objectives.
    2) Proposed revised Injury Control Objectives for Canada and its provinces.
    3) A list of issues needing clarification and decision.
    4) An agenda for the Year 2000 Symposium.

As a result of this process, each of the five working groups at the Year 2000 Symposium were supplied with four sets of materials to provide a starting point for discussion: goals; target-setting considerations; objective selection criteria; and a set of draft objectives. These are described in more detail as follows:

Goals for Working Groups:

* Develop objectives
* Set targets
* Identify data sources for monitoring achievement of specific objectives
* Identify agencies responsible for monitoring specific objectives.

Considerations for Setting Targets:

* Base line levels
* Recent trends
* Demographic changes
* Likely effect of implementing available strategies
* Resources needed for implementing strategies

Criteria for Selecting Objectives:

* Credibility
  Objectives should be realistic and relevant and should address issues of greatest priority.

* Public Comprehension
  Objectives should be understandable and relevant to a broad audience, including those who plan, manage, deliver, use and pay for health services.

* Comprehensiveness
  Objectives should be a mixture of outcome and process measures, recommending methods for achieving changes and setting standards for evaluating progress. Process measure should be restricted to those that have been shown to be effective or cost effective.

* Measurability
  Objectives should be quantifiable.

* Compatibility
  Where possible objectives should be compatible with the existing goals of federal, provincial, territorial and municipal agencies.

* Recognition of Data Constraints
  The availability or form of currently accessible data should not be the principal determinant of the nature of the objectives; rather, alternate and proxy data should be used where necessary.

* Responsibility
  Objectives should reflect the concerns and engage the participation of professionals, advocates, and consumers, as well as federal, provincial, territorial and municipal departments concerned with injury prevention and control.

* Flexibility
  Objectives should be adaptable to local conditions.

* Accountability
  Identify those responsible for guiding efforts and implementing strategies to achieve objectives and for evaluating whether objectives are met.

Draft Objectives

For the Home and Community, Transportation, Violent and Abusive Behaviour and Occupational Health and Safety working groups, draft objectives were taken, with modification, from the US document "Healthy People: Health Objectives for the Nation". Draft objectives for the Sports and Recreation working group were developed by a steering committee.

IV WHAT WAS ACCOMPLISHED?

The intense two days of work over May 21-22, 1991, produced a draft set of objectives which will be used to ultimately fulfil the long term goal of formulating measurable, long term national injury control objectives.

The Year 2000 Symposium was based on the idea of management by objectives, which holds that some of the principles for determining management objectives for business could be applied to public health issues to improve the health of Canadians through health promotion and disease prevention. This recognizes that most of the major causes of death and disease in Canada have preventable elements.

After being written in first draft report form, the draft objectives will be circulated to Symposium participants and other injury control stakeholder organizations across the country for further evaluation and comment. It was agreed that further refinements to the objectives will be needed before the formal conference proceedings are written up and published in the Fall of 1991.

However, there were common thematic threads running through the conclusions and recommendations of the five working groups. These common concerns can be summarized in three broad recommendations:

* reduce the overall incidence of mortality and morbidity due to injuries.

* target injury reduction in the area of alcohol-related mortality and morbidity.

* improve data collection systems and enhance data use and monitoring.

The following pages represent a brief summary of some of the recommendations made by the five working groups. These recommendations will continue to guide the refinement process of setting specific objectives. The recommendations are based on identified areas of priority.

Recommendations

Each work group identified a number of opportunities to reduce injuries. Objectives were drafted during the Symposium focussing on priority opportunities which, if implemented, would significantly improve Canada's injury death and disability experience. Appendix V presents a summary of the Work Groups' deliberations and their preliminary national objectives.

Occupational Health & Safety Working Group

1. The Occupational Health and Safety working group recommends that injury reduction objectives focus on specific industries and occupations as well as the primary industries such as fishing, farming, forestry, mining and petroleum.

2. Potential monitoring agencies identified as those most appropriate for providing injury data/statistics and monitoring changes to the injury problem were: Workers' Compensation Board (provincial and territorial), Canadian Centre for Occupational Health & Safety, Labour Canada and The Canadian Association of Administrators of Labour Legislation.

Transportation

1. The Transportation working group recommends that injury reduction objectives deal with reducing motor vehicle injury by addressing motor vehicle and driver standards, the surveillance and enforcement of motor vehicle standards, occupant restraint usage, driver skills and roadway environment.

2. Potential monitoring agencies identified were: Health and Welfare Canada, Canadian Council of Motor Transport Administrators, Canadian Association for School Health and Traffic Research Foundation

Sport & Recreation

1. The Sport and Recreation working group recommends that that a primary focus be placed on setting objectives related to increasing and improving risk management programs in sports and recreation activities. These objectives should encompass community, school, competitive, non-competitive and recreational programs and activities

2. A very fundamental deficit identified in the field of sport and recreation was the lack of current monitoring systems and monitoring agencies to identify and priorize areas of concern. The organization "Hockey Canada" was identified as the potential agency able to provide developmental guidance to provincial organizations.

Home & Community

1. The Home and Community working group recommends that injury reduction objectives be targeted to the following injury types: burns, drowning, falls, poisoning and off-road vehicle use.

2. Potential monitoring agencies identified included the following: Provincial fire authorities, Children's Hospitals' Injury Research and Prevention Program, Vital Statistics, hospital separation data, Statistics Canada, Health and Welfare Canada, Childhood Accident and Injury Reporting and Education System.

Violent & Abusive Behaviour

1. The Violent and Abusive Behaviour working group recommends that injury reduction objectives focus on the following: homicides and assaults, child abuse and neglect, inter-spousal violence, suicides, elder abuse and neglect, and adult sexual assault.

2. Potential monitoring agencies were identified as police agencies, provincial social services, and provincial hospitals.

Apart from these recommendations, two areas of general concern were apparent almost from the moment the Year 2000 Symposium began. As with the preceding recommendations, the following will be dealt with in more detail in the Fall 1991 Symposium Proceedings.

DATA DEFICIENCIES

The Problem

There is a lack of comprehensive data about injuries. There also exist major problems with definitions and with categorization of injuries. It will be difficult to monitor the achievement of these national objectives where the definitions are poor and data sources are inadequate or non-existent. There is jurisdictional variability and thus problems comparing data between provinces. Considerable underreporting of certain kinds of injuries also exist. There is also the concern of data sensitivity, of not infringing on the rights of particular ethno-cultural, socio-economic or age groups by collecting certain information that may be regarded as essential for data base purposes but objectionable from a human rights perspective.

The Solution

There is a need to build a coordinated provincial and national framework for a comprehensive injury surveillance system. It is important to establish ways of measuring whether or not the implementation of national injury control objectives is having an effect on injury prevention. The first step is to standardize the national injury data reporting system. Existing data bases must be used more effectively to maximize consistency and enhance linkage and coordinating. Ways of collecting important data not presently being collected must be explored. Major data gaps must be identified and filled as thoroughly as possible.

IMPLEMENTATION

The Problem

All of the issues dealt with at the Year 2000 Symposium are time sensitive. A lengthy consultation or ratification process might defeat the purpose of creating national consensus and acceptance of the draft objectives. Opportunities present themselves daily to influence policy and funding decisions from the community level to the regional and national levels. What approach can be taken to implement the results of the Symposium in a timely manner, so that the Final Report does not gather dust on shelves across this country?

The Solution

The draft objectives must be written down as quickly as possible in report form and circulated to all Year 2000 Symposium participants and other stakeholder groups in the injury control field. This would allow people to make comments and seek input from a wider group of people on the final Symposium Proceedings. The objectives must be kept on the political agenda and used as the starting point for discussions about how they could be implemented.

Symposium participants agreed that each would have as a personal goal the distribution of the objectives to organizations or groups in their own jurisdictions. This would help create an injury control awareness forum within each province, making sure that a nation-wide information network is established.

It was also agreed that two years from the date of the Year 2000 Symposium a follow-up session should be planned to determine progress to date and how the objectives are faring federally, regionally, provincially and locally. What was accomplished at the Symposium was gathering material to prepare a first draft document; it is important to plan for the second step and not let momentum dissipate.

The national objectives should be implemented in four categories:

* education and information to the public and to professionals:
* community based programs in the area of safety, and injury prevention and control;
* direct services such as emergency services for injury/trauma and access to professional counselling for violent and abusive behaviour;
* new legislation, regulation and enforcement initiatives.

V CONCLUSION

The first National Symposium to establish Injury Control Objectives for Canada for the Year 2000 met with an enthusiastic reception from all participants. However, it is important to emphasize that this event is just the beginning of an effort to establish national, multi-sectoral consensus on establishing priority injury control objectives for Canada.

This document, with its outline of the Year 2000 Symposium, is part of that initial effort.

The draft set of injury control objectives will be prepared and circulated during the Summer of 1991. These will include specific, measurable objectives as well as sources of data that will be used to track these objectives and the identification of a lead agency/organization that would monitor progress. Year 2000 Symposium participants will ensure that the draft objectives are circulated as widely as possible within their own jurisdictions; the comments thus gathered will be used to prepare the Symposium Final Report during the Fall of 1991. Linkages will also be established to ensure that the foundation is laid for a nation-wide information sharing network of both large and small stakeholders in the field of injury control.

The objectives generated by the multi-disciplinary, multi-sectorial group of delegates, and the thought-provoking discussions that followed, indicated that there is a broad commonality of interest and concern among professionals in the injury control field. The Year 2000 Symposium will enable these shared interests and concerns to be focused, for the first time, on preparing a national agenda for the prevention and control of injury.

VI APPENDIX I

FUNDERS

The National Symposium to Establish Injury Control Objectives for Canada for the Year 2000 could not have taken place without the assistance of its funders. We wish to thank them for their concern and their generous assistance in making this unique event possible.

Health & Welfare Canada
University of Alberta Hospitals
Alberta Health
Alberta Solicitor General
Alberta Occupational Health & Safety
National Health Research and Development Program

In particular, we wish to thank the members of the University of Alberta Hospitals' Injury Awareness and Prevention Centre for their work in organizing and coordinating the Year 2000 Symposium.

VII APPENDIX II

PARTICIPANTS

The National Symposium to Establish Injury Control Objectives for Canada for the Year 2000 offered a unique opportunity for a sensitive, comprehensive and multi-sectoral approach to solving the growing problem of a lack of clear, measurable health objectives for all Canadians. Over 100 people participated in the Year 2000 Symposium, representing a broad cross-section of people who are stakeholders in the field of injury prevention, including doctors, nurses, researchers, injury survivors, injury advocates, federal, provincial and territorial government representatives, and specialists in the areas of sports medicine, transportation, and occupational health. Without their dedication and enthusiastic participation, the Year 2000 Symposium would not have been the resounding success it was:

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VIII APPENDIX III

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IX APPENDIX IV

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X APPENDIX V

WORK GROUP NOTES:
Preliminary Draft Injury Control Objectives

OCCUPATIONAL HEALTH AND SAFETY

ISSUES

1. High risk vs. High priority.
2. How low is attainable?
   - Best available world std.
3. Statistics language depersonalizes injuries.
4. Magnitude of problem not recognized. (especially occupational health).
5. Social norm that injuries at work are inevitable.

TARGET AREAS

Occupational diseases

Fatalities

Backs

Hands

Cuts and lacerations

Health care

Construction

Primary - fishing, farming, mining, forestry, petroleum

Manufacturing

Young workers

New workers

ACCESS TO INFORMATION

- when you need it
- authoritative source
- reliable
- codes/standards
- toxicological
- cause and effect
- work practices
- uniform and consistent statistics

EDUCATION

Health professionals

Professions - medical
- engineering (equipment design)

Managers

Workers

School curriculums

Communities

Business - small
- self-employed

STRUCTURE

- VWHS committees
- contracting relationships
- business licensing
- financial accountability

ERGONOMICS

- implement preventive solutions.

EFFECT PUBLIC POLICY

- risk attitudes
- real costs

PROTECT CANADIAN STANDARDS

- when competing in international markets.

OCCUPATIONAL HEALTH AND SAFETY - HEALTH STATUS

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
Reduce national rate of deaths from work-related causes, by 30%.	5.7 per 100,000	Labour Canada	
Reduce jurisdictional rate of work-related injuries and illnesses in:		Prov./Terr. WCB	
High Risk Industries	30%		
Low Risk Industries	15%		
Reduce national rate of work-related back injuries.	30%		
Reduce jurisdictional rates of work-related back injuries.	reduction		

OCCUPATIONAL HEALTH AND SAFETY - DATA

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
Standardize the national injury data reporting system.	Jan. 1994		
Implement the standardized system in all jurisdictions.	2000		
Identify and design additional data systems to supplement the national injury data reporting system in special areas of concern.	2000		

OCCUPATIONAL HEALTH AND SAFETY - STANDARDS

OBJECTIVES	DATA TARGET	MONITORING SOURCES	AGENCIES
Exposure to known OCC health hazards will be reduced by measurably improved compliance with existing standards. (e.g. WHMIC, NOISE, OELs, TLVs).	Compliance in 90% of sites inspected.		
Undertake a national review, and where needed, modify, standards for physical and chemical agents.	50% of standards.		
Adopt the revised, uniform standards.	All jurisdictions.		

OCCUPATIONAL HEALTH AND SAFETY - PROGRAMS

OBJECTIVES	DATA TARGET	MONITORING SOURCES	AGENCIES
Implement health and safety programs in workplaces with:			
20 or more workers.	90%		
6-19 workers.	50%		
Credible, accurate, authoritative OHS info available to workplaces.	90%		
Prepare, and begin implementation of plans to mandate OHS care * for all workers.			
Require OHS compliance as a condition of business licensing.			
Increase the number of clients/ users/subcontractors who have OHS responsibilities defined in construction and maintenance contracts.	to 60%		
Increase the percentage of primary Health Care providers who routinely elicit occupational health exposures as a part of patient history and provide relevant counselling.	to 50%		

* Universal, accessible, portable, accredited, worker-oriented.

- started selection of specific objectives.

Occupational Health & Safety Issues.

1. Data base concerns:

- WCB claims, not injuries.
- interjurisdictional variation.
- under reporting (esp. occupational illness)
- WCB claims, not injuries.
- exposure/risk data not available.
- "rates" not available (at risk group not standardized).

PROCESS

- brainstormed on issues and potential objectives.
- reviewed data bases and problems with existing statistics.
- identified approach to using available stats.

PRESENT DATA BASES

1. Provincial, WCB claims data, including rates.
2. Employment injuries and occupational illness (Labour Canada) - no rates.
3. Work injuries (Stats Canada) - no rates.
4. Accidents in Canada (Stats Canada) - infrequent.

OCCUPATIONAL HEALTH & SAFETY

- present data source is principally WCB claims not injuries.
- little recognition of occupational illnesses, so few claims to WCB and poor data base.
- no recording of cause of injury.
- inconsistent recording standards between jurisdiction so no national data base providing rates.

OCCUPATIONAL HEALTH AND SAFETY - EDUCATION

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
Include prevention, recognition and treatment of occupational injury/ illness in educational programs for all health care practitioners.			
Include recognition of occupational health and safety hazards, and preventive measures in the curricula of: - engineering schools - business/management schools (including continuing education).			
To eliminate the shortfall of specialists in OHS disciplines, provide adequate training opportunities in: occupational medicine occupational nursing occupational hygiene ergonomics safety engineering	9/13 jurisdictions by 1995.		
Jurisdictions to evaluate their OHS information dissemination programs, and increase the availability of E.S.L. and low literacy materials.	All 500%		

DISCUSSION POINTS

- Youth
  - Behavioral problems prevalent in 9-10 year-old kids of (long-haul) truck drivers/away from home a lot.
  - Kids in high school with jobs in order to support their desires for, especially, clothes.
  - Start in day care centres; ex. Halifax has videotapes and colouring books that bring health and safety "information" to preschoolers (Consider impact on daycare workers too).
  - Safety awareness in all schools, as is done in the NWT with their 6-hour programs (Kids will take the ideas and knowledge home to their parents).

- Noise-Induced Hearing Loss

- Lack of integration between provincial injury data bases (WCB data bases)
  - several different sets of standards (moving toward greater standardization/Stats Can system).

- Declining institutional infrastructure in some areas of occupational health and safety, ex. toxicology.

- Occupational health and safety as an isolated aspect of people's 'lives', rather than as a part of their lives.
  - Some employers with good "handle" on health and safety at their workplaces, still have problems of absenteeism, injured workers injured off-the-job.

- High risk injuries with low global impact (affects small proportion of population), ex. forestry.

- Low rate injuries, that have a wide base of affected population, ex. back injuries.

- How low a rate, for a particular kind of injury, is attainable? That is, what rate can reasonable be expected to be obtained, considering current practices?

- Education Programs
  - Availability of training in occupational health and safety to various groups:
  - Improve the training of all physicians to recognize occupational injuries and illnesses. The unsafe conditions in medical treatment facilities attest to the low priority given to occupational health by the medical community.
  - Community health nurses.
  - Other health care professionals.
  - Union safety representatives.
  - Business people through CSSE's Project Minerva; PM to move into the medical areas as well?

- Reduction of fatalities
  - overall
  - specific industries
  - specific occupations

- Questionable reliability of occupational injury data
  - Some companies include their administrative staff when computing their accident rates;

others do not - data not comparable.
- Governments reducing data-collection activities; others who pick up the task may not be as reliable or as unbiased.
- Claims that were not accepted aren't included in the occupational injury data.
- Some whole industries, eg., agriculture, missed by the current occupational injury data.
- Some injured workers don't make claims (a whole host of reasons, such as company loyalty), and therefore aren't included in the injury data.
- Data can be used as a gauge, but not as an accurate indicator.
- Alternates to current injury data collection systems, i.e., WCB data:
  1) Sentinel event notification systems, such as the experience of health care providers whom serve a particular community
  2) Surveys
  3) Registers
- Information is costly.
- Existing systems were designed to pay people, not to collect injury data; but they can provide some useful information. Improve these systems to make them more useful, even if not ideal.
- Decide what data is needed.
- When a new system for collecting occupational injury data is developed, involve ohs professionals in its design.
- If the data on occupational injury is bad, the data on occupational disease is pathetic.
- Possible use of data linkages to relate health, WCB, etc. data (as done in Sweden). Very useful for developing data re occupational illnesses.
- Data taken by physicians doesn't include "occupation" or "workplace".

- Who should be deciding what is an occupational illness or injury?
  - CAALL may become involved in the recognition of occupational illnesses.
  - Good system for occupational illnesses would include:
    1) measurement of exposure
    2) machine-readable data
    3) central (federal?) control point
    4) voluntary or regulated recording of data/or incentives (WCB incentives) to record data
  - Use of private insurance company data.

- Occupational diseases.

- Develop more joint work site health and safety committees
  - Focus for action.
  - Resource.

- Information for non-organized workers, ex. in fast food outlets.

- Include health and safety studies as part of the standard curriculum in high school.
  - Build attitudes/habits favoring good health and safety on the job, rather than the acceptance of injuries as part of the culture of some jobs.
  - IAPA's "CLASS" program, in schools.

- Breaking through the acceptance of injuries as a natural, expected state-of-affairs, by both workers and employers.
  - Example: NIHL, back injuries.

- Occupational health and safety considerations re disabled (physical/mentally) people.
  - Training programs for such challenged people.

- Integration of occupational health and safety into the mainstream of Canada's health care system; i.e., treatment is available as part of the system, but prevention is not. (Canadian Medical Association is working on this).
  - Political unattractiveness of prevention - no charisma.

- Health care industry as a target.

- Impact of non-work injuries on work.

- Factor "occupational health and safety" into the cost of doing business.
  - Inform new businesses about legal ohs responsibilities.
  - Encourage basic occupational health and safety programs.
  - Aim to reduce injuries as a "cost-reduction" measure.
    1) Cost-reduction to industry
    2 0 Cost-reduction to the health care system, and in turn, to taxpayers.
    Develop costs and inform the public through a promotional/advertising campaign.
  - Devise means to make industry bear the total cost of the injuries and illnesses it causes, i.e., give employers a financial incentive to ensure that work at their sites is done safely.
  - Large companies/contractors to influence sub-contractors, eg., sub-contractors to adopt the occupational health and safety program of the principal contractor as one of the conditions of getting a job.
  - Union contracts to include occupational health and safety.
  - Build on total loss control.
  - (WCB costs to a company or industry do not represent the total costs of the occupational injuries in that company or industry).

- International perspective
  - Maintain competitiveness in a global economy.
  - Protect Canadian occupational health and safety standards from erosion in the name of business competitiveness.

- Award government contracts only to companies with good occupational health and safety programs.

- Improve existing data by adding "workplace" and "occupation" to physician's data on patient.

- Building occupational health and safety specifications into contracts for equipment, ex., design of new equipment.

- Incidents/near-misses.

- Statistical language depersonalizes/sterilizes the meaning of the figures.

- New workers.
- Ergonomics.

- 30% decrease in (death)? rate in high risk industries.
  15% decrease in ? rate in low risk industries
  on a province-by-province basis.

- Encourage WCBs to standardize their record-keeping systems.

- Encourage the development of data linkages between health, WCB, environment, census, etc. data as needed to get baseline data on occupational injuries
  - get labour support for this system to help them.
  - data handling by ? non-governmental organization?

- Record prevalence of disability related to injuries.

- Record incidence of injuries.

DRAFT OBJECTIVES

EDUCATION PROGRAMS

Improve availability of training in occupational health and safety to various groups:
- Physicians: Improve the training of all physicians to recognize occupational injuries and illnesses
- Community health nurse
- Other health care professionals
- Union safety representatives
- Workers
- Business people/managers
- Small business/self-employed people
- Engineering, eg. equipment design
- Schools
- Day care centres

TARGET AREAS

- Youth
- Noise-Induced hearing loss
- Fatalities: overall, specific industries, specific occupations
- Occupational diseases
- Backs
- Hands
- Cuts and lacerations
- Construction
- Health care industry
- Primary industries: fishing, farming, forestry, mining, petroleum
- Manufacturing
- Young workers
- New workers
- Disabled workers
- Incidents/near-misses
- Ergonomics
- 30% decrease in (death?) rate in high risk industries, on a province-by-province basis
- 15% decrease in ? rate in low risk industries, on a province-by-province basis..

IMPROVEMENT OF DATA SYSTEMS

- Encourage WCBs to standardize their record-keeping systems.

- Encourage the development of data linkages between health, WCB, environment, census, etc. data as needed to get baseline data on occupational injuries.
  - get labour support for this system to help them.
  - data handling by? non-governmental organizations.

- Record prevalence of disability related to injuries.

- Record incidence of injuries.

STRUCTURE

- Joint Work site Health and Safety Committees
- Information to non-organized workers
- Contracting relationships
- Business licensing
- Financial accountability

ACCESS TO INFORMATION

- Toxicological information: institutional infrastructure declining
- Authoritative source
- Reliable
- Codes/standards
- Cause/effect
- Work practices
- Uniform and consistent
- Statistics

EFFECT PUBLIC POLICY

- Risk attitudes
- Real costs

PROJECT CANADIAN STANDARDS

- International competition.

OTHER POINTS

- Integration of occupational health and safety into the mainstream of Canada's health care system; i.e., treatment is available as part of the system, but prevention is not. (Canadian Medical Association is working on this).
  - Political unattractiveness of prevention - no charisma.
- Impact of non-work injuries on work.
- Award government contracts only to companies with good occupational health and safety programs.
- Improve existing data by adding "workplace" and "occupation" to physician's data on patient.
- Building occupational health and safety specifications into contracts for equipment, ex., design of new equipment.

General

Anticipating 1987-89 *Employment Injuries and Occupational Illnesses* from Labour Canada (update of the 1985-87 versions distributed at the symposium). This document may provide baseline data for many of the objectives.

Notes for the narrative that introduces the Occupational Health and Safety section of the report:

The first thing that should be realized is that almost all Canadians are workers. Very few Canadians do not work full-time or part-time, at home or outside the home. Workers aren't nameless, faceless people; they're us.

Several pervasive and out-of-date attitudes have to be turned around:

1. Occupational health and safety is something separate from people's "real" lives.

   On the contrary, occupational health and safety has to become an integral part of our overall life safety. A very large proportion of our lives is spent at work. Safety at work is an impor-
   tant a component of our "whole lives" as the use of seat belts, rails on our basement stairways,
   etc.

2. Injury is a natural, and expected, part of working for a living.

   This is just plain nonsense. There's no reason why workers should have to contribute their health or well-being to their jobs. The reasonable expectation is that working will not result
   in injury or ill-health. When Canadians come to realize this fact, injury on the job will become
   socially unacceptable, just like drinking and driving, and its rate will be reduced accordingly.

3. The purpose of the health care system is to deal with injury and illness retroactively.

   So long as these attitudes prevail, the cost of the health care system will continue to spiral upward. Eliminating the cost of preventable injury from current health care costs would make the system affordable. Turning the emphasis of the health care system to preventive, rather than corrective approaches has to become the aim of personnel in the system and taxpayers.

The lack of information about injuries, illness, death, and their causes, is a major impediment to evaluating occupational health and safety efforts in Canada. This situation results from the fact that WCB data is the only source of information. WCB systems were designed for paying insurance claims, not for providing information on the needs and the effectiveness of health and safety programs. One of the ways the problem would be overcome without going to the great expense and difficulty of setting up new data systems would be the linkage of existing health, compensation, hospitalization, employment and death records, using social insurance numbers as the essential link. Canadians strenuously resist such data linkages. The price of this privacy assurance is less-than-optimal information about the current occupational health and safety picture. And of course, without accurate information about the current situation, it's not possible to plan and implement the best programs for protecting the health and safety of Canadian workers.

FATALITIES

Fatalities from all work-related causes.

Reduce the national rate of deaths from work-related causes, by 30%.

Baseline: Average of 8.2 per 100,000 over the years 1987 to 1989
Labour Canada OSH Statistical Bulletin, April 1991 (average of 7.9, 8.4, and 8.3 per 100,000, for the years 1987, 1988, and 1989, respectively).

Rationale: U.S. objectives are aim for a reduction of >30% but their tie for achievement is longer. 30% reduction seems appropriate for the 9-year (probably 8 years of less by the time the objectives are disseminated) period for achievement.

Narrative: Deaths from work-related causes are not acceptable. It must be the objective of all persons involved in occupational health and safety, to eliminate work-related deaths. However this ultimate objective won't be reached in the short term. The objective of 5.7 or fewer deaths per 100,000 workers by the year 2000 is an interim objective en route to the achievement of the only acceptable number of on-the-job deaths - none.

Efforts to reduce deaths will result in reduce injuries as well.

Work-Related Death Rate (per 100,000)	87-89 Average	2000 Target
Canada	8.2	5.7

Consider: Do we want to add rates for the mining, construction, transportation, and farm sector (as done in the U.S.), and for forestry and petroleum (as suggested by Canadian pre-symposium participants and included in the Draft Objectives document that was included in the binder distributed at the symposium)?

Work-Related Death Rate (percent)	1987 Average	2000 Target
Agriculture	2.2	1.5
Construction	17.1	12.0
Forestry	9.1	6.4
Mining	15.5	10.9
Petroleum		
Transportation	16.4	11.5

Baseline: The 1987 figures below are taken from Labour Canada's "Employment Injuries and Occupational Illnesses 1985-87", Table 11.

The Year 2000 targets represent a 30% reduction.

INJURIES

Injuries, from all work-related causes

Reduce the jurisdictional rates of injuries from work-related causes, by 30% in high risk industries, and by 15% in low risk industries.

Baseline: 1987-89 (three-year rolling average) from jurisdictional Workers' Compensation records. **Are we sure that the WCBs compute and publicize these 3-year rolling averages every year?**

Narrative: The attitude that injuries are an inevitable result of working must be eliminated. Canadians must come to expect that they and their co-workers need not be injured on the job any time during their working lifetimes. Continued,

significant reductions in injury rates will make a major contribution to this attitude change.

The jurisdictions are the provinces, the territories, and Labour Canada. High risk industries are those with injury rates greater than the jurisdictional average for the period 1987-89; low risk industries are those with injury rates lower than the jurisdictional average.

Work-Related Death Rate (per 100,000)	1987-89 Average	2000 Target
Alberta		
British Columbia		
Labour Canada		
Manitoba		
New Brunswick		
Newfoundland		
Northwest Territories		
Nova Scotia		
Ontario		
Prince Edward Island		
Quebec		
Saskatchewan		
Yukon Territory		

Injuries, by part of body

Reduce the national rate of work-related back injuries by 30%.

Baseline data: 196 work related back/spine injuries in 1987.
Statistics Canada's "Accidents in Canada, February 1991; Table 12."
Need to find total number of employees in 1987 in order to get # back injuries/
100,000 workers and calculate 70% of that percentage as a year 2000 target.

Reduce the jurisdictional rate of work-related back injuries by 30%.

Baseline data: Not found. (Is it in Statistics Canada's Work Injuries 1987-89?)

Injuries, by industry

Consider: Do we want to set objectives for injury reduction for a number of target industries
- by kind of industry as well as by 'industry-risk-group'? The U.S. objectives
included construction, "nursing and personal care workers" (health care?), farm,
transportation, and mining. The Canadian pre-symposium participants added the
logging industry for the establishment of this kind of objective.

Work-Related Injury Rate (percent)	Current Average	2000 Target
Agriculture		
Construction		

Forestry
Health Care
Mining
Transportation

Baseline: The Year 2000 targets represent a 30% reduction.

DATA NEEDS

Making the best use of current Canadian data sources.

Standardize the national injury data reporting system by January 1994.

Implement the standardized national injury data reporting system in all jurisdictions.

Development of additional data systems as needed.

Identify and design additional data systems to supplement the national injury data reporting system in special areas of concern.

Narrative: These additional systems would be designed to suit the needs of data users. For For example, a system for identifying and enumerating occupational diseases is needed. (Table 4 in Labour Canada's "Employment Injuries and Occupational Illnesses" provides some of this information). "Cause of injury" is another area where additional data may be required.

Making use of international data sources.

Identify and obtain the international data sources necessary to determine the lowest work-related death and injury rates in the world.

Narrative: The lowest work-related national death and injury rates will be major data points in

setting the future Canadian targets. The 2010 targets will be either these lowest rates attained, or if Canada is already near these targets, lower figures that represent a reasonable target for Canadian employers and workers to achieve.

EDUCATION

Narrative: Provide education for Canadians in the recognition and prevention of work-related

hazards. The level and extent of this education will need to be adjusted to the needs of specific groups. For example, high-school students who are part-time workers need different needs than experienced industrial workers; disabled persons in sheltered workshops have different needs than able-bodies, new Canadian who haven't learned the language yet; information handlers have different needs than chemical handlers; etc. Occupational health and safety education must extend outside the workplace to the children, the spouses, and the parent of working people, for these influential persons make a major contribution to the learning done by their parents, spouses, and adult children.

There's also a great need to provide educational materials in **plain language.**

Health Care Practitioners

Include prevention, recognition, and treatment of occupational injury/illness in educational programs for all health care practitioners.

To eliminate the shortfall of specialists in occupational health and safety disciplines, provide adequate training opportunities in:
- **occupational medicine,**
- **occupational nursing,**
- **occupational hygiene,**
- **ergonomics, and**
- **safety engineering in 9 of 13 jurisdictions by 1995.**

Commentary: Change to 9 of 12 jurisdictions, since Labour Canada is not an appropriate jurisdiction for this purpose.

Other Professionals

Include recognition of occupational health and safety hazards, and preventive measures in the curricula of:
- **engineering schools, and**
- **business/management schools, (including continuing education)/**

Workplaces

Make credible, accurate, authoritative occupational health and safety information available to 90% of workplaces.

Narrative: CCOHS Info Disk would satisfy the information requirements of this objective.

All jurisdictions to evaluate their occupational and safety information dissemination programs, and increase the availability of 'english as a second language' and low literacy materials by 500%.

High Schools

Establish, in at least 5 of 12 jurisdictions, injury prevention programs in schools.

or the alternative. . .

Establish school "safety programs" in order that students become "work-proofed".

Narrative: These safety programs should address workplace hazards in general, but should also have a construction orientation because this is a common workplace for students.

STANDARDS

Reduce exposure to known occupational health hazards, by achieving measurably improved compliance with existing standards in each jurisdiction.

Compliance Rate	Current Rate	2000 Target
Alberta		90%
British Columbia		90%
Labour Canada		90%

Manitoba	90%
New Brunswick	90%
Newfoundland	90%
Northwest Territories	90%
Nova Scotia	90%
Ontario	90%
Prince Edward Island	90%
Quebec	90%
Saskatchewan	90%
Yukon Territory	90%

Undertake a national review of the jurisdictional standards for at least 50% of the physical and chemical agents currently regulated. Modify as needed to produce uniform national standards.

Adopt the revised uniform standards in all jurisdictions.

Narrative: WHMIS compliance may be easier to measure than that of some other standards. Noise, as the most ubiquitous occupational health hazards, should receive special compliance attention. In many jurisdictions, much data gathering will be needed to determine the current level of compliance.

Occupational health standards, especially OELs (TLVs), are now about 20 years old. Review is needed to ensure that they are still adequately protective.

PROGRAMS

Implement health and safety programs in workplaces with 6 or more workers.

Number of Workers	Current % with H&S Programs	2000 Target
6-19		50%
≥20		90%

Prepare and begin implementation of plans to mandate occupational health and safety care for all workers.

Narrative: The care would need to be accessible, universal, accredited, and worker-oriented.

Increase to 50% the percentage of primary health care providers who routinely elicit occupational health exposures as a part of patient history and provide relevant counselling.

Suggested in the draft objectives as modified by pre-symposium participants, and provided to symposium participants.

Ensure that all work sites with 50 or more workers offer back injury prevention programs.

Establish consultation and assistance programs in occupational health and safety, to farms and very small businesses (1-3 employees).

OTHERS

Require compliance with occupational health and safety legislation as a condition of business licensing.

Commentary (DLS): Business license may be issued before operations being. There may be nothing to inspect to determine if compliance with the legislation is being achieved. Alternately, the company may be in compliance initially, but may deviate from that practice as time goes on. Losing their licence as a result of deviating from compliance would amount to the same thing as being "shut down" for that reason. Does this objective put us any further ahead than we are now?

Increase the proportion of clients/users/subcontractors who have occupational health and safety responsibilities defined in construction and maintenance contracts.

ISSUES/OBJECTIVES REMAINING 'ON THE TABLE'

Reduce jurisdictional rates of cumulative trauma disorders by 30%. (Cumulative trauma disorders include noise induced hearing loss and repetitive strain injuries).

Eliminate exposures that result in workers having blood lead concentrations >2.0 mmol/L.

Tolerance of substance abuse while or before working will disappear, and be replace by an attitude of public disapproval. EAPs.

Cross labelling through the use of symbols will be adopted on personal protective equipment and chemical products that could pose a risk for occupational disease, in all jurisdictions.

Increase to 80% the proportion of construction work sites with 20 or more workers who have established Joint Work Site Health and Safety Committees.

Workplace injuries and deaths are not acceptable - this attitude change is necessary.

Public policy targets Considerable discussion about setting such targets. Funding to empower workplace stakeholders, as evidence of public commitment, was discussed as a possible area for objective-setting. The establishment of a National Injury Awareness Promotion Fund was discussed. Do we want to go ahead with setting objectives in this area, or will we leave this as a strategy area that objective-achievers can adopt?

Political interest/support

Access to information

Public awareness

Students

RSI

Noise

Incidents

New Workers

Recording the prevalence of disability related to injuries

Record the incidence of injuries

Remaining from Draft Objectives documents

#4.0 re skin disorders
#5.0 re hepatitis B infections
#6.0 re use of seatbelts, fire resistant work wear
#7.0 re proportion of workers exposed to noise levels in excess of 85 dBA
#9.0 re hepatitis B immunizations among occupationally exposed workers
#11.0 re occupational lung disease

TRANSPORTATION

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
Data Objective Improve surveillance and detection with respect to morbidity arising from MVC's with a focus on emerg room, police reports and health sequalae including the detection of other impairing substances.			
Increase to 100% the number of jurisdictions that have mandatory Motor Vehicle Inspections for all class of vehicles.	100% of jurisdictions	Number of jurisdictions	CCMTA
Increase by 10% the number of collisions attributable to deficiencies in the design, construction and maintenance of the roadway environment.	Decrease by 10%.	TRAID (National Accidental DataBase)	CCMTA
Increase to 50%, the number of jurisdictions in Canada that have graduated licence systems in place by the year 2000.	50% increase	Count the jurisdictions	CCMTA
Identify and implement effective skill development and training programs which will minimize the risks of deaths and disability, especially injury from MUC's.		Baseline inventory of current level of skills and training plus studies of which programs are effective. (e.g. CCMTA, CAA, H&W, Driver Training Assoc.)	CCMTA
Increase the emphasis on the leading risks of death and disability especially injury from MUC, in the educational programming in schools.		Establish base-line monitoring system.	Canadian Association for School Health

TRANSPORTATION

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
a) Reduce the proportion of alcohol impaired fatally injured drivers by 20%.	20% reduction	Fatality DataBase.	Traffic Injury Research Foundation.
b) Increase use in Canada of Administrative Licence Suspension and Vehicle Impoundment.	50% of jurisdictions		CCMTA
Increase usage of occupant restraint systems oto 95% by 1995. (NORP-CCMTA) and maintained at that level or higher thereafter.	95% usage.	CCMTA/Transport Transport Canada Seat Belt Survey	CCMTA/TC
Reduce fatal and non-fatal injuries cause and by transportation crashes. Reduce fatal and non-fatal injuries due to MVC (MVC includes on-road and off-road vehicles). Young adults 15-24 yrs. Children-≤ 14. Reg. Indians/Inuit. People aged 65+.	20%	Fatality and Hospitalization Data National Accident DataBase.	Health and Welfare/ CCMTA
Reduce fatal and non-fatal injuries. Registered Indians/Inuit Males		Fatality and Hospitalizations	Vital Statistics (stats Canada and Morbidity Data (stats. Canada) Hospital Media Records Institute (HMRI) for Hospitalization Data.
Issue: As a general principle don't make a distinction between intentional and unintentional.			
Incorporated into 1.0			
Issues: Combine intentional and unintentional.			
Need for preamble to accompany objectives to define and describe terms.			
Brain (head) and spinal cord injuries are a significant result of motor vehicle crashes and deserve attention.			
Registered Indians/Inuit - 15 definable.			

SPORT AND RECREATION

GLOBAL OBJECTIVES

1. Decrease the number of fatal and non-fatal injuries in all types of injury.
2. That the use of alcohol and drugs be recognized as a significant contributor to injuries in all areas and research into its impact be aggressively targeted.
3. Influence each provincial ministry of education to adopt a "behavioral curriculum" objective that "each student will demonstrate an awareness, an attitude, and actions that will prevent injury and thereby enhance the quality of life".
4. That data bases be developed to identify specific areas of concern and allow for monitoring the effects of interventions.

SPORT AND RECREATION

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
Increase to at least _____% the proportion of national and provincial sport, fitness, recreation and school associations and agencies who operate a "risk management program" in charge of overlooking all safety matters in their sport. Issues should include but not be confined to:			
1. Increase to at least _____%, the proportion of volunteer coaches and officials trained in CPR and First Aid.			
2. Increase the awareness of sport and recreation injury prevention and control in community and provincial programs by developing resources to be delivered through provincial sport and recreation organizations.			
3. Develop and implement emergency department sentinel networks.			
4. Increase to at least _____%, the proportion of primary care givers who routinely provide age appropriate counselling on safety precautions to prevent sport and recreation injuries.			
5. Implement and coordinate an educational package in sport safety, injury prevention, and management in the school system.			
6. Enhance the sport safety programs in the community-based recreational and competitive athletic programs.			

HOME AND COMMUNITY - FIRE

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
Reduce residential fire Deaths due to: 1) smoking 2) cooking equipment 3) child fire play 4) auxiliary/space heaters		Fire Commissioners Reports Coroners CHIRP/CAIRE Local burn units/ hospitals Health Insurance (Prov.) Pre Hospital/Stats (Need E-codes)	Provincial Fire Authorities Health & Welfare Provincial Q.A.
Morbidity - as above			
High Risk Priorities - Poor - Aboriginal - Disabled - Young - Elderly			
Interventions: On maintenance of achievements and extension to high risk groups. Smoke alarms Residential sprinklers (Edmonton and Legislative) Fire Safe Cigarette Fire Resistance Fabrics on furniture			
2) Residential Water Heaters - Reduce mortality and morbidity	High Risk - young, elderly, disabled		
Intern by reducing thermostats at the factory and educating installers not to raise it.			
3) Scalds - research			

Data

Fire Commissioners Report

Coroners - E-coding to be better.

Recommend consistent stat taking in fire incidents.

CHIRP - Children Hospital Injury Reporting and Prevention.

CARE - only Consumer & Corporate Affairs.

Regional Hospital - find of inactives.

Pre-hospital Services statistics i.e.: ambulance.

Health Care Insurance?

Morbidity - hospitalization

a) reduce residential fire deaths due to:
   - smoking reduce
   - cooking equipment
   - children playing with fire
   - space heaters

b) Same for time injury (?) morbidity.

c) Target groups
   - poor
   - aboriginals
   - disabled.

d) Interventions:
   - technology
   - upkeep/maintenance
   - legislative

- residential sprinklers
- smoke alarms
- fire resistance cigarette (slim?)
- child resistant lighter
- furniture manufacturer
- children: clothing - broader for more ages
- education - ?
  - plan to get out

- Recommend that there should be a registry of Educational Programs/Resources with Fire Commissioners Office.

- Legislation - SQ/space/Fire doors
  GSA/ULC

- BBQ on balcony

- Look at alcohol related injury

- Cooking - thermostatically deep fat frying
  - education

- Space heaters - electric - education
  - fuel - improper fuel.

- Separate - burns by scalds/hot water.
  - intervention - reduce thermostat on hot water heater - 120^{o}
    in hospital/nursing homes (accurate thermostat on heaters).
  - _____ of _____? who set properly.
  - Factory set thermostat.
  - Thermostats valve (CSA passed).
  - _____ for research - hot liquid - hot drink/kettles.

Note: Farming/rural?

- Falls in Daycare - leading site for head and neck injury.

- Preamble - re: alcohol/substance abuse.

- Environmental

- "Passive" intervention - control lighter.

HOME AND COMMUNITY

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
Drowning	children 0 - 4 5 - 1 4	medical examiner/ coroner reports	
	seizure prone	deaths date Vital Statistics	
	aboriginal	hospital separations	
	rural	emergency	CHIRP
	overlap recreational boating/fishing occupational	pre-hospital data other coast guard	

* unsupervised/general
supervised transportation standardization

* Alcohol

DROWNING

Objective	Data Source
Reduce drowning deaths by x per 100,000 population (age-adjusted baseline)	coronary medical examiners reports
Reduce drowning deaths in males 15-34. (recreational, boating, alcohol)	Vital Statistics
Reduce drowning deaths in males 35+ (boating, fishing)	
Reduce drowning deaths in children aged 0-6 (developmental stage, parental supervision, environmental factors)	
Reduce drowning related mortality in seizure prone individuals.	
Reduce near drowning related morbidity in all age groups.	Hospital Separation Data CHIRP

1. Increase adherence to barrier devises such as fences, pool covers through education legislation and enforcement.

2. Decrease alcohol related drowning morbidity and mortality through legislation and reinforcement.

3. Increase mandatory wearing of personal floatation through education, legislation and enforcement.

4. Provide accessible, age-appropriate and culturally sensitive education programs.

* Poor, aboriginal and disabled populations require specifically targeted strategies.

* Drowning objectives must also include those related to the occupational and transportation area.

OFF ROAD VEHICLES

Note: This includes any motorized vehicles capable of speeds _____ whether used recreational or not, e.g. A.T.V.'s, snowmobiles, off road motorcycles, motorized water vehicles (sea-doos).

Objectives:

1. Reduce off road vehicles-related mortality by (20%).

2. Reduce off road vehicle-related morbidity by (20%).

3. All operators of off road vehicles should be licensed in accordance with existing requirements for motorized vehicles such as automobiles and motorcycles.

4. All drivers and passengers on off road vehicles should be mandatory.

Strategies:

1. Legislation will fail unless there is some degree of preparation and acceptance by the community. In all communities with excessive use of off road vehicles and/or excess morbidity therefrom, vehicle safety programs should explicitly address the use of off road vehicles.

2. Manufacturers should be encouraged, through lobbying and standards, to design safer off road vehicles.

Data Sources:

1. Vital Statistics.

2. Hospital admission-separation data.

3. Provincial territorial statutes.

4. Data sources for strategies:
   a) Periodic telephone survey at community level.
   b) ?

	SOURCE
1. Reduce ATV and Snowmobile related mortality to x per 100,000.	Vital Statistics
2. Ditto...morbidity.	Admission
3. All jurisdictions should require licensing of all individuals who operate ATV's and snowmobiles (off road vehicles)? (recommendation?):	Legislation
4. In those jurisdictions with high use/and or excess morbidity from ATV and snowmobile crashes, all vehicle safety programs should also deal with off road vehicles.	

	SOURCE
5. Use of helmets mandatory when operating off road vehicles (drivers and passengers).	Legislation

(recommendation?):
6. Research re: structural modifications to off road vehicles.

Interventions:

1. Education and possibly testing of road skills and knowledge of cyclists.

2. Formation of comprehensive and cohesive coalitions to educate the public, make helmets available at reasonable cost and pursue legislation of mandatory bicycle helmet usage.

3. New bicycles will not be sold nor will a bicycle be rented unless proof of ownership of an approved helmet is demonstrated or a helmet is concurrently purchased or, for rentals - rented.

4. Enforcement of current laws for cyclists.

HOME AND COMMUNITY - FALLS

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
1. Reduce deaths from falls (age standardized).			
2. Reduce deaths from falls.	0 - 4 5 - 1 4 6 5 - 7 4 7 5 + Native, poor, rural	Vital Statistics Workmans' Comp. Death	Health & Welfare Labour Canada MSB
3. Reduce hospitalization from falls.	0 - 4 5 - 1 4 6 5 - 7 4 7 5 + Aboriginal Poor	Activity Limitation Survey Labour Form Survey Vital Statistics HMRI Disability Days	Statistics Canada Labour Canada Health & Welfare
4. Reduce product related falls.	children elderly	CHIRP/CAIRE	MSB
5. Reduce head and neck injuries			

FALLS

Risk Groups

Children, elderly.

Objectives

To reduce deaths from falls among elderly:
6 5 - 7 4 8 5 +
7 5 - 8 4

Data Source: Vital Statistics

To reduce morbidity from falls and fall related injuries.

< 1	15-24	85+
1-4	65-74	
5-14	75-85	

Data Source: HMRI, Ski Patrol, _____ Spine, Head and Neck Injury, CHIRP, CAIRE (_____), Activity Limitation Survey.

To reduce injuries from falls from playground equipment among children, 1-14 years.
Data Source: hospitalization, CHIRP, provincial trauma registries.

Extend compliance with CSA playground standards to _____.
Data Source: survey

To reduce non-fatal head and spinal injuries (acne age group as 5.1)
Data Source: Canadian Sports-Spine-Head Injury, Research Centre, Hospitalization, Provincial Trauma Registries.

Enact in all provinces where skiing is practical, reg. requiring ski hill operators to provide accurate:
- uniform signage on the slopes,
- to enforce the international code of conduct for skiers.

Data Source: Ski Patrol Data

To promote initiatives to reduce injuries resulting from aggressive behavior in sport.
Data Source: Hockey Centre of Excellence . Focus on media.

Recommendation:

1. Review utilization of effective head, face, eye, mouth and neck protection in sport.

2. To establish trauma registries in all provinces.

3.

HOME AND COMMUNITY - RECREATION

OBJECTIVES	TARGET	DATA SOURCES	MONITORING AGENCIES
1. At the competitive level approved helmets be mandatory for both practices and events.		CHIRP for peds./ CAIRE. Local surveys of usage.	Local coalitions Prov. Transport/ Highways Dept.
2. At all mass participating cyclethon events, the use of approved helmets be a mandatory condition of participation.		Local hospital injury studies. Trauma Centres HMRI?	
3. Bicycle helmet usage will be used by the majority of cyclists. (Reduce head injuries). High risk groups: Mort./Morb. 5-9, teenagers, poor.		Stats Canada/ Coroner reports for mortality. (Estimates 5000 injuries, 60 deaths in children.	

Local survey of usage
Local studies of injuries
CHIRP

1. Elite level approved helmets be mandatory for all practices and events.

2. All bicycle promotions should depict the proper use of approved helmets.

3. New bicycles will not be sold nor will a bicycle be rented to an individual of any age unless proof of ownership of a helmet is demonstrated or a helmet is concurrently purchased/rented.

4. At all mass participating cyclethon event approved helmets be made mandatory as a condition of participation.

5. Bicycle helmets will be used by the majority of cyclists.

High risk groups children 5-9, teenagers.

Focal coalitions be focused to educate the public, make helmets available at reasonable cost and promote legislation of mandatory approved bicycle helmet usage.

POISONINGS

1. Reduce non-fatal poisonings among preschoolers:
   4 year | ER
   | P. Cont.?
   | Contive?

2. Establish standardized way for collecting data.

3. Establish poison centre centres in each province.

4. Extend legislation on child resistant containers to include all drugs.

5. Standardize legislation in all provinces.

Recommendations:

a) Education for parents - IPECAC

b) Discourage manufacturers from producing candy-like vitamins.

c) Pediatric re: should be prescribed as medic.

d) Place warning labels re: poison plants.

e) Child resistant containers on all household products.

VIOLENT AND ABUSIVE BEHAVIOR

1. We endorse measurable objectives re: violent and abusive behavior in the form presented (trend in injuries duets violent & abusive behavior).

2. Relatively satisfied with mortality data for the purposes of objetctive setting (homicides and suicides) albeit underreporting occurs.

3. Dissatisfied with morbidity data in all areas including child, senior, inter-spousal abuse, sexual assault and physical assault.

4. We recognize a need to activate an upward trend in services and protection (measurable objective).

5. We would expand the definition of injury to include psychological trauma.

6. We recognize that practice follows attitudes and awareness, setting practice objectives is limited in this area in the absence of the formula.

"Attitude change is the precursor to knowledge and skill development".

(individual - societal).

1. To reduce homicides and fatal assaults in Canada.

high-risk populations	current homicide rate	Year 2000	mortality data base
all Canadians	1.95	?	CCJS
children 0-4 yrs.	1.58	?	
males 15-34 yrs.	3.58	reverse the trend?	
aboriginal Canadians		reduce to level of general population	
Spouses -			
children-in-care adolescent, youth, young adults			social services CCJS

* These categories could be broken down by weapon used, etc.

1. Table (b) - Adults (not seniors)

high-risk population	current physical assault rate	Year 2000	hospital morbidity data base - CUVS
all Canadians	45.42	?	GSS CJS
males 15-34 yrs.	139.45	?	
spouses			
females 15-34 yrs.	39.96	?	
aboriginal Canadians			

* ICD-based and hospital admissions

Sources - gen. statement
- need for resources for data collection and analysis clearinghouse(s)
  - multi-functional
- network

2. To reduce deaths, suicide injury in Canada.
Table (a) mortality - 1984-1988 (STD 1971).

high-risk populations	current suicide rate	Year 2000	Source
all Canadians	12.26	?	- mexamial - coronor - mortality data-base - Suicide info database.
males 15-19 yrs. 20-24 yrs.	20.49	?	"
males 25-34 yrs.		?	"
older males (65+)?	29-19	?	"
aboriginal Canadians	3-7 x Canadian rate		

2. Table (b) Attempted suicide.

high-risk populations	current rate of attempted suicide	Year 2000	Source
all Canadians	52-98	?	- hospital morbidity data
females, young 15-19 to 25	224.57	?	Daveys
young males 15-19 to 25	106.16	?	
aboriginal	inadequate data		

3. To reduce the incidence of non-fatal injuries due to child abuse and neglect in Canada.

Notes re: unreliability of data.

a variety of sources of current data could be listed e.g.
- school records
- CHIRP
- child welfare
- public health _____(?)
- hospital morbidity database
- victimization survey of adults
- provincial health care
- 0 - 2
- adolescents

High Risk
- children in care
- aboriginal children
- immigrant children
- disabled children

4. To reduce inter-spousal injuries in Canada

High Risk	Current Rate	Year 2000	Source
All Canadians			
Female	1/10		
Male			
Aboriginal			

5. To reduce the incidence of injuries due to elder abuse and neglect.

High Risk Targeted	Current Rate	Year 2000	Source
All Canadians			- surveys - hospital morbidity data
Disabled			"
Mentally Ill			"
Immigrants			"
Aboriginal			"
In Care			"
Isolated			"

6. To reduce the incidence of sexual assault of adults.

High Risk Population	Current Rate	Year 2000	Source
			- CJS data - courts - police - surveys - troutline service agencies